Premier
Orthopaedic & Sports Medicine Associates, LTD.

Today's Date: _____

Name:_____Date Of Birth:_____SS#_____

Address:_____ Apt#_____

City:_____State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail:_____

Marital status (circle one): Single Married Partner Widowed Separated Divorced

***Race:_____ *Religion:_____ (*required by Medicare)**

Emergency Contact:_____ Phone number:_____

Relationship:_____

Primary Care Physician:_____ Who Referred you:_____

Primary Care Physician ADDRESS:_____

Do You want a report sent to your physician? YES NO

PHARMACY NAME:_____

ADDRESS:_____ PHONE:_____

Is problem related to Worker's Comp (WC)_____ or Car Accident (MVA)_____? YES NO

PLEASE GIVE ALL INSURANCE CARDS TO THE FRONT DESK

MEDICARE
BlueCross/Blue Shield
Aetna HMO/Aetna PPO
Cigna PPO
Keystone First
Other _____

Keystone HMO
Personal Choice
Commercial
Bravo
Self

WC or MVA: Must complete below
Insurance:_____
Address: _____
_____
Adj name/phone _____
Claim# _____
Date of Injury_____
Employer_____

*****MUST ALSO PROVIDE PRIVATE INS INFO*****

REASON FOR VISIT:

Body Part:_____ **□ Right □ Left □ Bilateral**

□ Pain □ Swelling □ Locking □ Other:_____

Describe in your words: _____

_____

_____

_____

Did you bring any Diagnostic Images (i.e. Xrays or MRI) with you today? □ Yes □ No

What type of study:_____ **Where was study done?**_____

WHAT IS THE MAIN PURPOSE OF YOUR VISIT? WHAT DO YOU WANT TO ACCOMPLISH?

_____

***ALLERGIES*: Please list ALL MEDICATION allergies and/or reactions (ex: hives, nausea)**

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

***MEDICATION LIST*: Please list all prescription, over the counter, vitamins & dietary supplements.**

MEDICATION	DOSE	REASON

Do you take Joint Supplements (Glucosamine or Chondroitin Sulfate)? YES NO Which Brand?

HISTORY OF PRESENT ILLNESS:

Onset of injury/Pain:_____

Cause: □ No Specific Injury □ Injury □ Sport Injury □ Work Injury □ MVA (car accident)

□ Trauma Type:_____ **Where:**_____

□ Exercise or Fitness related? (explain)_____

□ Uncertain (i.e. no obvious cause or reason)

Doctors that have treated this problem:_____

List treatment if any:_____

Injections? Yes No Cortisone or steroid? Viscosupplementation (i.e. Synvisc)?

Prior surgery to involved area?_____

_____

Severity Of Pain: 1 2 3 4 5 6 7 8 9 10

Frequency/Status: □ Intermittent □ Occasional □ Constant

Status: □ Improving □ Worse □ Stable □ Unchanged

Does the pain Radiate to other areas? □ Yes □ No Where?_____

Aggravated By:

□ Bending □ Climbing stairs □ Descending stairs □ Lifting □ Twisting □ Pushing

□ Sitting □ Standing □ Walking □ Other:_____

Relieved By:

□ Brace/Splint □ Elevation □ Exercise □ Heat □ Ice □ Injection □ Massage □ Mobility

□ Pain/Rx Meds:_____ **□ OTC Meds:**_____

□ Physical Therapy □ Rest □ Stretching □ Other:_____

Associated symptoms:

□ Bruising □ Numbness □ Crepitus (cracking sounds) □ Difficulty going to sleep

□ Decreased Mobility □ Instability □ Limping □ Locking □ Popping □ Spasms

□ Night pain □ Swelling □ Weakness □ Tenderness □ Other:_____

HEIGHT_____ WEIGHT_____ Recent weight GAIN or Loss? Amount?_____

REVIEW OF SYSTEMS: **Please check all that apply:**

Constitutional: □ Fatigue □ Fever □ Night Sweats □ Weight Loss/Gain _____

Cardiovascular: □ Chest Pain □ Irregular heartbeats _____

Skin (Integumentary): □ Rash □ Psoriasis □ Tick Bites Other:_____

Metabolic/Endocrine: □ Cold Intolerant □ Heat Intolerant _____

HEENT: □ Headache □ Vision Loss _____

Gastrointestinal: □ Ulcer □ Constipation □ Diarrhea □ Nausea □ Vomiting _____

Neurological: □ Difficulty Walking □ Dizziness □ Balance Problems □ Falls _____

Hematologic/Blood: □ Bleeding □ On BLOOD THINNERS (which one?)_____

Respiratory: □ Cough □ Dyspnea (shortness of breath) _____

Genitourinary: □ Difficulty urinating (Dysuria) □ Blood in urine (Hematuria)_____

Immunological: □ Environmental/seasonal Allergies □ Food Allergies _____

MEDICAL HISTORY: **Please check all that apply: □ NONE**

□ AIDS/HIV
□ Alcoholism
□ Alzheimer's
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Benign Prostatic Hypertrophy
□ Cancer:_____
□ Stroke
□ CHF
□ Myocardial Infarction
□ Osteoporosis
□ Psoriasis
□ Rheumatoid Arthritis
□ Sleep Apnea
□ Thyroid Disease
□ COPD
□ Coronary artery disease
□ Crohn's Disease
□ Anxiety
□ Depression
□ Diabetes
□ Drug Abuse
□ Blood Clot (DVT)
□ Fibromyalgia
□ Gallbladder Disease
□ GERD
□ Gout
□ Obesity
□ Parkinson Disease
□ PVD
□ Scoliosis
□ Lupus
□ Valvular Disease
□ Hepatitis
□ High
□ High Blood Pressure
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory bowel disease
□ Rheumatoid Arthritis
□ Kidney Disease
□ Liver Disease
□ Lyme Disease
□ Migraine Headaches
□ Multiple Sclerosis
□ Osteoarthritis
□ Peptic Ulcer Disease
□ Renal Disease
□ Seizure Disorder
□ Spinal Stenosis
□ Fibromyalgia
□ Other:_____

SURGICAL HISTORY: **(Please check all that apply)** **□NONE**

□ACL Surgery	**□CABG (Heart Bypass)**	**□Hernia Repair**
□Arthroscopy (Scope):	**□Heart Valve replacement**	**□Hip replacement**
□Meniscus Surgery	**□Carpal tunnel release**	**□Knee replacement**
□Microfracture	**□Cataract Extraction**	**□Colectomy**
□Cartilage Regeneration	**□Gallbladder removal**	**□LASIK**
□Angioplasty (stent: yes / no)	**□Hysterectomy**	**□Mastectomy**
□Low Back Surgery	**□ Colostomy**	**□Muscle Biopsy**
□Neck Surgery	**□Gastric Bypass**	**□TURP / prostatectomy**
□Fracture Surgery	**□Pacemaker**	**□Small Bowel Resection**
□Thyroidectomy	**□Tonsillectomy**	**□Cesarean Section**

□Other_____

Family Medical History: ***Indicate any medical problems or illnesses***

Father:_____

□ Living □ Deceased

Mother:_____

□ Living □ Deceased

Social History:

Do You Smoke?_____ **Packs a day?**_____ **How Many Years?**_____

Do you drink alcohol?_____ **How often?**_____

Activity/Exercise Level: □Sedentary □Moderate □Vigorous

Type(s) of exercise:_____ **How many times per week?**_____

PATIENT'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S SIGNATURE: _____

HIPPA ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE & DISCLOSE HEALTH INFORMATION

ACKNOWLEDGMENT AND CONSENT

I acknowledge that I have been offered the Notice of Privacy Practices for Premier Orthopaedic & Sports Medicine Assoc.LTD and that I authorize the use and disclosure of health information about (name)_____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient/Representative Date

Authorization For Release of Information and Direct Payment to the Doctor

DIRECT PAYMENT: I authorize and direct my Insurance Carrier(s) to make payments for medical or surgical treatment, injections, supplies and x-rays directly to Premier Orthopaedic & Sports Medicine Associates, Ltd. I hereby authorize the submission of all information necessary to complete this claim. These authorizations shall be effective for myself and my dependents. I agree that a copy of this authorization shall be as valid as the original.

MEDICARE and MEDIGAP: I request that payment of authorized MEDICARE AND MEDIGAP benefits be made either to me or on my behalf to the physician named below for services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents to my MEDIGAP insurer and any information needed to determine these benefits or the benefits payable for the related services.

I understand and agree that I am responsible for payment of all charges not fully paid by my insurance

Patient's Signature _____Date_____